State of Rhode Island

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942
Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

DWC No. _____

Insurer File No.

1. EMPLOYER LOCATION:

FEIN 05-6000522
Name Department of Corrections
Address 39 Howard Ave.
City, State, Zip Cranston, RI 02920
Phone (401) 462-3251 Ext. Type of Business Government
RI Unemployment Ins. No. NAICS 922140

2. EMPLOYER NAMED ON WC INSURANCE POLICY: ☐ SAME AS BLOCK 1

FEIN
Name STATE OF RHODE ISLAND
Address
City, State, Zip
Phone Ext.
WC Policy Number

3. INSURANCE COMPANY NAMED ON WC POLICY:

FEIN
Name STATE OF RHODE ISLAND
Address
Address
City, State, Zip
Phone Ext.

4. CLAIM ADMINISTRATOR: ☐ SAME AS BLOCK 3

FEIN 05-6000522
Name Department of Administration
Address State Emploees' Workers' Compensation
Address One Capitol Hill
City, State, Zip Providence, RI 02908-5866
Phone (401) 222-6570 Ext.

5. EMPLOYEE INFORMATION:

SSN ☐ Male ☐ Female
Name
Address
City, State, Zip
Phone Date of Birth
Occupation Date Hired
State of Hire Preferred Language of Employee: O English O Spanish O Portuguese O Other:

6. MEDICAL INFORMATION:

Treatment Facility
Address
City, State, Zip
Phone Ext.

7. WITNESS INFORMATION:

Name Phone

8. INJURY INFORMATION:

Injury Date
Time injury occurred ☐ AM ☐ PM
Time employee began work ☐ AM ☐ PM
1. First full day lost from work ☐ NONE LOST
2. Date returned to work (if appropriate)
3. Date employer notified of injury
If fatal - **REPORT WITHIN 48 HOURS** - Date of death

What was person doing when injured?

List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)

Place where injury/illness occurred: ☐ At employer location listed in Block 1 **OR** Complete address where accident occurred:

Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☐ No

If Yes, date employer first notified of medical treatment or time lost

Category(ies) of injury or illness: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown

Print Name of Report Preparer | Date Prepared | Phone & Extension

Print Name of Employer Contact Person OR ☐ Same as above | Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	